Applied Assessments LLC

An Independent Review Organization

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Notice of Independent Review Decision

Case Number: ***Date of Notice:*** 04/20/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesology

Description of the service or services in dispute:

OP Intrathecal Pain Pump Trial

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

This patient is a male who received a left stellate ganglion block on 11/07/13 for a diagnosis of left upper extremity causalgia, RSD. On 02/05/15, the patient was seen in clinic and it was noted he had attended 5 sessions of a chronic pain management program. He reported pain to his elbow going down to his fingertips. It was noted he was psychologically stable to undergo and benefit from an intrathecal Dilaudid and Fentanyl trial at that time. On 02/24/15, the patient was seen in clinic and pain was rated at 7-9/10 at that time. Methadone seemed to be helping in lowering dosing.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 02/11/15, a notification of adverse determination was submitted for the requested intrathecal pain pump trial and while it was noted that the patient was reporting pain that was creating interference in his life the documentation provided for review noted there is no evidence of improvement in pain and function in response to oral opiate medications but intolerable adverse effects precluded their continued use. Therefore the request was non-certified due to the lack of evidence of improvement in pain and function in response to oral opiate medications but intolerable adverse effects precluded their continued use. On 03/23/15, a notification of reconsideration adverse determination stated that it appeared the patient was achieving appropriate analgesia with Methadone and it was recommended that the patient decrease Duragesic as of his last clinical record of 02/24/14. It was noted the prior reviewer's concerns were not addressed and the determination remained unchanged.

Guidelines indicate that for the use of this type of treatment, non-opiate oral medication regimens should have been tried and failed to relieve pain and improve function, and there should be documented improvement in pain and function in response to oral opiate medications but intolerable adverse effects precluded their continued use. The records provided for this review include a 02/24/15 progress note indicating that the patient had pain rated at 7-9/10 and Methadone seemed to be helping in lowering dosing. The records indicated that a progress note dated 02/18/15 reported Methadone was helping but was too strong. Therefore it appears this patient is still being able to be managed on oral Methadone without

significant side effects. The rationale for the intrathecal pain pump therefore has not been documented. It is the opinion of this reviewer that the requested outpatient intrathecal pain pump trial is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)